Filed for intro on 02/02/95
House Bill_____
By
_____

Senate No. SB0734
By Cooper

AN ACT to amend Tennessee Code Annotated, Title 56; and to repeal Tennessee Code Annotated, Title 56, Chapter 7, Part 22, and to enact the "Tennessee Affordable Health Insurance for Small Businesses Act of 1995".

WHEREAS, increased access to affordable health care is a primary goal of the citizens of Tennessee; and

WHEREAS, the state has implemented TennCare, a plan to provide adequate health care subject to strict managed care requirements to those who are currently covered by Medicaid and to those who are uninsured; and

WHEREAS, some five hundred thousand (500,000) Tennesseans are underinsured but are not eligible for coverage under TennCare; and

WHEREAS, many of these underinsured Tennesseans work for small companies or are family members of such workers; and

WHEREAS, less expensive health insurance will enable many more Tennesseans to provide adequate health insurance for themselves and for their families, thereby relieving the public burden; and

WHEREAS, community rated health insurance for groups of from two (2) to one hundred (100) employees would substantially decrease the cost of such insurance for working Tennesseans; and

WHEREAS, ensuring that every employee of a small company will be guaranteed insurability regardless of pre-existing condition, health condition, smoking status or any other factor other than medical service area is a realistic method to decrease the cost of and increase access to health insurance; and

WHEREAS, preventing so-called “cherry picking” or “cream skimming” will result in decreased cost of and increased access to health insurance for all Tennessee workers who work for small companies and for the families of such workers; and

WHEREAS, the interests of Tennessee require the enactment or bold, courageous statutory measures to ensure increased access to quality health care; now, therefore,

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. The title of this act is, and may be cited as, the “Tennessee Affordable Health Insurance for Small Businesses Act of 1995.”

SECTION 2. It is the intention of the general assembly to promote affordable guaranteed issue health insurance plans for employees of Tennessee’s small businesses through community rating and managed health care that will increase access to and continuity of coverage for their employees.

SECTION 3. Tennessee Code Annotated, Title 56, Chapter 7, Part 22, cited as the “Tennessee Small Employer Group Health Coverage Reform Act”, is hereby repealed and sections 4 through 12, inclusive, of this act, are substituted as a new Part 22.

SECTION 4. As used in this act, unless the context otherwise requires:

(a) “Agent” means an individual who has an agency contract or agreement with a company to solicit or negotiate a policy of insurance on the company’s behalf;

(b) “Community rate” means the underlying rate that a company utilizes in calculating all premium rates for all eligible groups assigned to a community health agency area;

(c) “Community health agency area” means any one of the areas in which a community health agency has been established by the commissioner of health pursuant to the Community Health Agency Act of 1989, compiled in Title 68, Chapter 2, Part 11. For purposes of this act, an eligible group shall be assigned to the community health agency area in which a majority of the eligible employees of such eligible group routinely perform their work for the eligible group as of the effective date of the eligible group’s small group health plan or the date of renewal of the plan. If there is no such majority in any one community health agency area, then such eligible group shall be assigned to the community health agency area in which the largest number of such eligible employees routinely perform such work.

(d) “Company” means any insurance company, hospital, or medical service corporation, health maintenance organization or other business enterprise of any type, which, acting as a principal, shall issue or renew any small group health plan according to managed care requirements;

(e) “Dependent” means the spouse or child of an eligible employee and shall include a dependent child until such child attains age twenty-four (24);

(f) “Eligible employee” means an employee who works on a full-time basis, with a normal work week of twenty-four (24) or more hours, including a sole proprietor, a partner or a partnership, but does not include employees who work on a part-time, temporary, or substitute basis;

(g) “Eligible group” means any person, firm, corporation, partnership, association or other business enterprise of any type in whatever form conducted, engaged actively in a business that during at least fifty (50) percent of its working days in the calendar quarter preceding application for coverage or renewal of coverage employed more than

one (1) and not more than one hundred (100) eligible employees, the majority of whom were employed within the state. In determining the number of eligible employees for purposes of the application of this act, multiple business enterprises, in whatever form such business is conducted, that are eligible to file a consolidated federal income tax return shall be considered to be one (1) enterprise;

(h) “Eligible individual” means any eligible employee or dependent;

(i) “Guaranteed issue” means that an eligible group and each eligible individual that applies for coverage under a small group health plan cannot be denied coverage as long as minimum participation requirements are met;

(j) ”Guaranteed renewable” as it pertains to any small group health plan means that provision which allows the eligible group to renew coverage so long as minimum participation requirements are met, but which permits the company to increase or decrease premium rates for such plans consistent with this act. Nothing herein shall prohibit a company from withdrawal from further issuance of small group health plans subject to this act and from declining to renew small group health plans theretofore issued to their terms, and a provision permitting a company to do so shall not cause a small group health plan to fail to qualify as such.

(k)(1) “Health benefit plan” means:

(A)(i) any accident and health insurance policy or certificate;

(ii) any nonprofit hospital or medical service corporation contract;

(iii) any health, hospital or medical service corporation plan contract;

(iv) any health maintenance organization subscriber contract; or

(v) any plan provided by a multiple employer welfare arrangement or plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974;

(2) “Health benefit plan” does not mean:

(A) accident only, specified disease only, fixed indemnity, credit or disability insurance;

(B) coverage for Medicare services pursuant to contracts with the United States government;

(C) Medicare supplement or long-term care insurance;

(D) dental only or vision only insurance;

(E) coverage issued as a supplement to liability insurance;

(F) insurance arising out of a workers' compensation or similar law;

(G) automobile medical payment insurance; or

(H) insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self insurance.

(I) "Late enrollee" means an eligible individual who requests enrollment in a small group health plan following the initial enrollment period provided under the terms of the small group health plan; provided that such initial enrollment period shall be a period of at least thirty (30) days. However, an eligible individual shall not be considered a late enrollee if:

(I) the eligible individual:

(A) was covered under another small group health plan or other employee health benefit plan at the time the individual was eligible to enroll;

(B) stated, at the time of the initial enrollment, that coverage under another small group health plan or other employer health benefit plan was the reason for declining enrollment;

(C) has lost coverage under another small group health plan or other employer health benefit plan as a result of

termination of employment, the termination of the other plan's coverage, death of a spouse or divorce; and

(D) requests enrollment within thirty (30) days after termination of coverage provided under another small group health plan or other employer health benefit plan;

(2) the eligible Individual is employed by an eligible group that offers multiple small group health plans and the eligible Individual has elected a different plan during an open enrollment period and requests enrollment within thirty (30) days after the eligible Individual's coverage under such different plan is terminated; or

(3) a court has ordered coverage be provided for a spouse or minor child under an eligible employee's small group health plan, and requests enrollment within thirty (30) days after issuance of such court order;

(m) "Managed care requirements" means:

(1) that the company shall operate a program designed to assure that the eligible Individual, prior to incurring liability for hospital, surgical, medical or pharmaceutical services reimbursed or otherwise covered under any small group health plan, shall have secured:

(A) pre-admission certification of an inpatient stay;

(B) pre-authorization of home health care and durable medical equipment to be rendered on more than one day; and

(C) any required second medical opinion; and

(2) that the company prior to issuing any small group health plan shall have secured and shall maintain during the entirety of the period in which it is liable to reimburse for or otherwise to cover hospital, surgical, medical or pharmaceutical services:

(A) comprehensive provider participating agreements with the company that eliminate payment for unnecessary services, hold the patient harmless from payment for non-covered services or charges above allowable amounts, and utilize guidelines to assure quality and appropriateness of services covered by any small group health plan;

(B) a utilization review program;

(C) a hospital network under contract with the company in each community health agency area in which the company shall be soliciting small group health plans;

(D) a physician network under contract with the company in each community health agency area in which the company shall be soliciting small group health plans;

(E) a mental health network under contract with the company in each community health agency area in which the company shall be soliciting small group health plans;

(F) a pharmaceutical network under contract with the company in each community health agency area in which the company shall be soliciting small group health plans;

(G) a home health network under contract with the company in each community health agency area in which the company shall be soliciting small group health plans;

(H) a durable medical equipment network under contract with the company in each community health agency area in which the company shall be soliciting small group health plans;

(I) an infusion therapy network under contract with the company in each community health agency area in which the company shall be soliciting small group health plans; and

(J) a regular provider and subscriber communications explaining changes in the coverages of services.

(n) “Minimum participation requirements” means the percentage of eligible employees who must participate in a small group health plan. Such percentage shall be seventy-five percent (75%), but the calculation of such percentage shall give credit for enrollment of eligible employees in other employer health benefit plans;

(o) “Other employee health benefit plans” means an employee health benefit plan issued to an individual or group not covered by this act;

(p) “Pre-existing condition” means a policy provision that limits or excludes coverage for charges or expenses incurred during a period of twelve (12) months following the eligible Individual’s effective date of coverage, for a condition that had manifested itself during a period of twelve (12) months immediately preceding the effective date of coverage in a manner that would cause an ordinary prudent person to seek diagnosis, care or treatment, or for which medical advice, diagnosis, care or treatment was recommended or received during the twelve (12) months immediately before the effective date of coverage, or as to a pregnancy existing on the effective date of coverage;

(q) “Premium rate” means the dollar amount charged by a company for a specific set of benefits for the type contract selected by each eligible employee in a community health agency area;

(r) “Small group health plan” means a health benefit plan issued to an eligible group; and

(s) “Type contract” means the option selected by an eligible employee for individual or dependent coverage, including but not limited to, two-person, employee and children, or family coverage.

SECTION 5.

(a) No company shall issue or renew any health benefit plan providing reimbursement for or other coverage of hospital, surgical, medical or pharmaceutical care to any eligible group in this state unless such plan is a small group health plan issued in conformity with the provisions of this act.

(b) Within each community health agency area in which a company operates, no company shall deny coverage under a small group health plan to any eligible group making application therefor, or to any eligible Individual thereof for whom any required application is made, except for failure of such eligible group to comply with minimum participation requirements.

SECTION 6. Every small group health plan shall contain provisions which fairly, accurately and simply set forth the rights and obligations of the parties thereto and which:

(1) provide that it is guaranteed renewable by the policyowner;

(2) exclude payment for services or goods not medically necessary unless such services are rendered for covered preventive health services;

(3) provide that the benefits are covered only if managed care requirements applicable to an eligible Individual are met;

(4) provide that upon renewal on an annual basis, premium rate changes shall conform to the requirements in Section 7 of this act;

(5) use the community rate and any formulas and factors which the company then has on file with the commissioner in arriving at the premium rate upon the issuance, or renewal on an annual basis, of any small group health plan after January 1, 1996;

(6) provide coverage on a guaranteed issue basis to all eligible Individuals who are members of such eligible groups, except:

(A) for nonpayment of the required premiums;

(B) for fraud or material misrepresentation;

(C) for noncompliance with the minimum participation requirements; or

(D) if the company shall cease to issue or renew small group health plans in compliance with Section 10 of this act;

(7) provide each eligible Individual the right to receive from the company upon application therefor a group conversion plan available to a person insured under a small group health plan at the time when such eligible Individual becomes ineligible for further coverage under such plan; and

(8) provide for a pre-existing condition limitation which shall apply only to late enrollees.

SECTION 7. Every company issuing small group health plans and every agent for such company shall conform to the following rating practices for each such plan by:

(1) filing with the commissioner for informational purposes, prior to issuance of any small group health plan thereunder, the company's community rate for each community health agency area in which the company operates and any formulas and factors applied to the community rate to determine a premium rate;

(2) not varying the community rate except due to type contract, community health agency area and plan benefits;

(3) adjusting community rates and the formulas and factors filed with the commissioner at no time other than January 1 of each year; and

(4) not requiring or requesting answers to health questions as part of an individual or group application for small group health plan coverage or directly or indirectly determining approval or rejection of an eligible group by reference to health questions requested for other purposes including, but not by way of limitation, answers to health questions secured in connection with application forms for life insurance or health insurance not covered by this act.

SECTION 8.

(a) A small group health plan shall provide group health insurance benefits for those expenses which are covered by the group health insurance plan of the state of

Tennessee for its active employees as of January 1, 1995. Except as is otherwise provided in this section, a small group health plan shall provide for reimbursement or other coverage in amounts equal to those provided by the group health insurance plan of the State of Tennessee for its active employees as of January 1, 1995.

(b) A small group health plan shall contain a coinsurance provision, the effect of which shall be to limit the company's payment for covered expenses to a percentage not less than seventy percent (70%) nor more than eighty percent (80%) of any covered claim; provided, however, nothing herein shall prohibit a small group health plan from:

(1) providing for reimbursement or other coverage of such expenses in greater percentage, not to exceed ninety percent (90%) thereof, in the event services are provided by a member of a managed care network as described in Section 4(m)(2) of this act or in the event of emergencies as may be defined in such small group health plan; or

(2) reducing such percentage to an amount not less than fifty percent (50%) in the event an eligible individual shall fail to comply with the managed care requirements as set forth in Section 4(m)(1) of this act.

(c) Each small group health plan shall provide for a deductible amount, which shall be selected by the eligible group or by eligible employees within the eligible group, and such deductible amount shall be subtracted from any claim covered by such small group health plan prior to calculation of reimbursement or other coverage thereunder. No such deductible amount shall exceed one thousand dollars ($1,000).

(d) As soon as practical after the enactment hereof, the state group insurance committee shall determine the scope of group health insurance coverage that is required under the terms of this act. The chairman of the committee shall promptly thereafter and by January 1 of each subsequent year:

(1) make an official announcement of the terms of such coverage package;

(2) cause the dissemination of such announcement to the news media in such manner as the chairman deems appropriate;

(3) cause a description of the terms of such coverage to be published in the Tennessee Administrative Register; and

(4) thereafter furnish copies of such description at no cost to any person requesting a copy thereof.

(e) The commissioner shall:

(1) make available for public inspection all filings made by each company pursuant to this act, including but not limited to each company's community rate and any formulas and factors used to adjust such rate; and

(2) publish annually a listing of all companies doing business in the state. Such listing shall include all information necessary for eligible groups to compare small group health plans offered by each company. The commissioner shall publish such listing on or before January 31 of each year and shall include all community rates filed or adjusted by January 1 of that year. The commissioner shall publicize the availability of the listing in such manner as the commissioner deems appropriate and shall distribute the listing at no cost to any person requesting a copy thereof.

SECTION 9. Any company that issues or renews any small group health plans within a community health agency area may cease to issue and renew small group health plans in such area upon its compliance with each of the following requirements:

(1) Notice of the decision to cease issuance and renewal of such policies within a community health agency area must be provided to the commissioner and to each policyowner of such company's small group health plans within such area not less than six (6) months nor more than twelve (12) months prior to the date on which the company proposes to withdraw from the market;

(2) Any company that ceases to issue small group health plans shall continue to be governed by this act with respect to business conducted under this act; and

(3) Any company that ceases business within a community health agency area pursuant to this section shall be precluded from issuing any small group health plan covering any eligible group within such area for a period of five (5) years from the date on which such company gives notice of cessation to the commissioner.

SECTION 10. Each company and each agent of a company must meet the following standards of fair marketing:

(1) Each company must actively solicit small group health plan applications for coverage from eligible groups within any community health agency area in which the company issues small group health plans.

(2) No company or agent of a company shall directly or indirectly:

(A) encourage or direct any eligible group to refrain from making an application for coverage by reason of age, gender, industry or occupation, health or demographic characteristics of eligible individuals thereof; or

(B) encourage or direct any eligible group to seek small group health plan coverage from another company for any of the reasons stated in Section 7 and Section 10(2)(A) of this act.

(3) A company may not directly or indirectly enter into any contract, agreement or arrangement with an agent that provides for or results in the compensation paid to such agent in connection with the sale of a small group health plan to be varied based upon any factor other than benefit, community health agency area or type contract. Nothing in this subsection shall prohibit any company from entering into a compensation arrangement that provides compensation to an agent of the company on the basis of percentage of premium or other consideration paid with respect to such small group health plan.

(4) A company may not terminate, fail to renew or limit its agency contract or agreement of representation with an agent by reason of any factor listed in Section 7 or Section 10(2)(A) of this act.

(5) No company or agent of any company may induce or otherwise encourage an eligible group to separate or otherwise exclude any eligible employee from any small group health plan.

SECTION 11.

(a) Violation of this act shall be punishable by the commissioner by civil penalties not to exceed ten thousand dollars ($10,000) for each violation, by entry of an order requiring a person to cease and desist from further such violations, or by both. Such action by the commissioner shall be taken pursuant to Tennessee Code Annotated, Title 4, Chapter 5, and shall be reviewable by petition for review pursuant to Tennessee Code Annotated, Section 4-5-322.

(b) Any eligible group or eligible individual injured by reason of the issuance of a policy of insurance or other document providing coverage that fails to comply with the requirements of this act shall have a private cause of action against the insurance company or other issuing entity that issued the policy and shall recover treble any actual damages incurred by such person as a result of any denial of liability under such policy of insurance, but only if and to the extent that such denial of liability would not have been lawful under a small group health plan.

(c) Any company injured by reason of a violation of this act shall be deemed to have been irreparably injured thereby and shall have a private right of action to seek injunctive relief in circuit or chancery court enjoining further violation, along with compensatory damages.

SECTION 12. The provisions of Tennessee Code Annotated, Title 56, Chapter 5, Part 3, and Chapters 7 and 26 through 32, inclusive, shall not apply to small group health plans to the extent they are inconsistent with the terms of this act.

SECTION 13. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 14. This act shall take effect October 1, 1995, the public welfare requiring it.

AN Act to amend Tennessee Code Annotated, Title 56, and to repeal Title 56, Chapter 7, Part 22, and to enact the "Tennessee Affordable health Insurance for small Businesses Act of 1995".

AN ACT to amend Tennessee Code Annotated, Title 56, and to repeal Title 56, Chapter 7, Part 22, and to enact the "Tennessee Affordable health Insurance for Small Businesses Act of 1995".

AN ACT to amend Tennessee Code Annotated, Title 56, and to repeal Title 56, Chapter 7, Part 22, and to enact the "Tennessee Affordable Health Insurance for Small Businesses Act of 1995".

AN ACT to amend Tennessee Code Annotated, Title 56, and to repeal Title 56, Chapter 7, Part 22, and to enact the "Tennessee Affordable Health Insurance for Small Businesses Act of 1995".

AN ACT to amend Tennessee Code Annotated, Title 56, and to repeal Title 56, Chapter 7, Part 22, and to enact the "Tennessee Affordable Health Insurance for Small Businesses Act of 1995".

AN ACT to amend Tennessee Code Annotated, Title 56, and to repeal Title 56, Chapter 7, Part 22, and to enact the "Tennessee Affordable Health Insurance for Small Businesses Act of 1995".

AN ACT to amend Tennessee Code Annotated, Title 56, and to repeal Title 56, Chapter 7, Part 22, and to enact the "Tennessee Affordable Health Insurance for Small Businesses Act of 1995".

AN ACT to amend Tennessee Code Annotated, Title 56, and to repeal Title 56, Chapter 7, Part 22, and to enact the "Tennessee Affordable Health Insurance for Small Businesses Act of 1995".

AN ACT to amend Tennessee Code Annotated, Title 56, and to repeal Title 56, Chapter 7, Part 22, and to enact the

"Tennessee Affordable Health Insurance for Small Businesses Act of 1995".

AN ACT to amend Tennessee Code Annotated, Title 56, and to repeal Title 56, Chapter 7, Part 22, and to enact the "Tennessee Affordable Health Insurance for Small Businesses Act of 1995".